

The Use of Restraints in Psychiatric Settings

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INTRODUCTION

Psychiatric facilities often use medical interventions in the form of restraints to reduce safety risks posed by violent patients and to prevent patients from harming themselves and others. This paper reviews legal ramifications and risks associated with restraint, and a discussion on possible ways to prevent the use of unnecessary and risky restraint procedures.

DEFINITIONS

The definition of restraint can be found in the 'Patient's Rights' section of the Department of Health and Human Services (DHHS) Public Health Regulations (DATE).

"The term 'restraint' includes either a physical restraint or a drug that is being used as a restraint. A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body. A drug used as a restraint is a medication used to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition."¹

The Joint Commission on Accreditation of Hospital Organization (JCAHO) "Provision of Care, Treatment, and Services standard (PC.12.30) define restraints in two categories: (1) physical, or "any method of physically restricting a person's freedom of movement, physical activity, or normal access to his or her body" and (2) chemical, or "...inappropriate use of a sedating psychotropic drug to manage or control behavior."²

Protections against the improper use of restraint are now included in federal regulations governing hospitals (medical/surgical and behavioral health), nursing homes and Intermediate Care Facilities for the Mental Retarded (ICF/MRs).³ The federal regulations mandate less restrictive alternatives be attempted prior to the use of restraints and the procedures that must be followed when implementing a physician's order for restraints.⁴ The accrediting body, JCAHO, has specific standards which requires that competent staff, within facilities, strive to minimize the use of restraints and when it is absolutely necessary to restrain a patient, that the procedure is completed in a safe manner.² These protections and standards are supported among healthcare providers because of the inherent risk of harm and/or death while physically restrained. In addition, patients and their families often view patient restraints negatively and as a traumatic event. What is unclear to providers at times is determining when restraints are "absolutely necessary" and in defining the term "least restrictive alternative."⁵ As a result, improper use of restraints can lead to patient harm and potential civil litigation.

CURRENT LITIGATION

In 2005, an Alzheimer's patient was hospitalized and within 24 hours, after she was restrained, found dead. The county coroner called her death an accidental asphyxiation. A lawyer was obtained by the family to represent the family in a "wrongful death suit."⁶ In addition, the Department of Justice alleged that the hospital violated the False Claims Act by collecting Medicare payments without "following

federal rules on the use of chemical and physical restraints." The hospital agreed to pay the government \$200,000 and to hire a consultant to review restraint usage at the hospital as part of the agreement. The settlement focused upon financial fraud of government funding rather than the actual harm/danger to the patient.⁷

In 2005, Current Psychiatry reported a case where a woman was admitted to a county hospital psychiatric inpatient unit. Guards and technicians restrained her. During the restraint process her face was held down on the floor for 15 to 30 minutes and she died of asphyxiation. The estate sued the county and the technician's employer claiming the guards were not properly trained on restraints. A \$105,000 settlement was reached with the county and a confidential settlement was reached with the security employer.⁵

PREVENTION

Managing aggressive and violent behaviors has become an essential skill important to all involved with psychiatric patients. A large amount of evidence has been collected that demonstrates behavioral approaches to care can provide effective alternatives to reliance on restraint. Successful strategies such as clear guidelines and a comprehensive reporting requirement; commitment by management; adequate staffing levels; and staff training in the safe use of, and alternatives to, restraint are keys to prevention.³ Proper training increases the behavioral competence of all direct care staff while administrative structure encourages the competent application of behavioral skills and ensures effective oversight by those who are relatively more competent.⁸ In a

recent study, involving a public psychiatric hospital there was evidence of a decrease in restraint due to the process of training, identifying critical cases and initiating a clinical and administrative case review.⁹

Other studies reveal that competence in behavioral rehabilitation or behavioral competence among psychiatric direct care staff can be assessed by addressing quality measures such as internal consistency, temporal stability, content validity, construct validity and criterion related validity. These measures directly assess situations that direct care staff encounter in their daily practice and demonstrate that staff members who practice behavior competence recognize how the environment including their own behavior can influence the behavior of others. Such measures can also be used by clinical administrators to establish staffing patterns and plan programming changes.¹⁰

CONCLUSION

Despite advances in the management of acute psychiatric disorders, violent behaviors among inpatients continue. With or without restraints, there is always the possibility of a serious adverse event possibly leading to litigation. Although patient related violence remains problematic, Centers for Medicare/Medicaid Services (CMS) and JCAHO have emphasized the need to respect the patient's autonomy as well as reduce the possibility of harmful effects by decreasing restraints.¹¹

Programs to reduce restraints should be comprehensive. These should

consist of a high level of administrative support, staffing ratios, staff training, cultural changes, individualized treatment and data analysis. The increase in regulatory standards has also been associated with a reduction in the use of restraints and an improvement in patient care.¹² ■

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